Before the
Federal Communications Commission
Washington, D.C. 20554

In the Matter of	)	
	)	
Rural Health Care	)	
Support Mechanism	)	**WC Docket No. 02-60**
	)	

WORLDCOM, INC.
COMMENTS

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I. Summary

In this Notice of Proposed Rule Making ("NPRM"), the Commission seeks comments on various proposals to change the rural health care support mechanism.[1] More specifically, the Commission seeks comments on how it might treat eligibility of otherwise eligible entities that also perform functions that are outside the statutory definition of "health care provider"; how to best to provide support for Internet access; whether and how to streamline the application process; how to allocate funds if demand exceeds the annual cap; how to encourage partnerships with clinics at schools and libraries, and generally how to prevent waste, fraud, and abuse. WorldCom takes this opportunity to offer its comments on various issues raised in this NPRM.

WorldCom agrees with the Commission that the low percentage of rural health care providers (9%) participating in the rural health care program justifies policy changes that would increase program participation. The changes should focus more on measures that will increase participation, rather than measures that will dramatically increase the benefit per participant. Increasing participation to 50% will result in funding commitments of $60 million.[2] This would be a substantial increase in participation, would involve a substantial increase in funding commitments, but still maintain the fund at a size that would not require significant increases in surcharges by interexchange carriers. WorldCom makes the following observations and recommendations.

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[1] Rural Health Care Support Mechanism, Notice of Proposed Rulemaking ("NPRM"), WC Docket No. 02-60, Released April 19, 2002.

[2] Nine percent of health care providers (743) received funding commitments totalling $10.8 million in the third funding year. See, http://www.rhc.universalservice.org/funding/.

The Commission should adopt a prorated discount for rural health entities that would be eligible for rural health care support were it not for their affiliation with non-eligible entities. There is no statutory requirement for the Commission to exclude entities that would be eligible were it not for their affiliation with non-eligible entities, or their involvement in activities that are non-eligible for reimbursement under the rural health care program. The Commission may use the share of staff hours devoted to patients being cared for by the eligible portion of the entity to determine the appropriate benefit.

The Commission may subsidize access to Internet service provided by non-telecommunications carriers only for the difference between rates for urban and rural Internet access. Congress explicitly provided different funding mechanisms for rural health care clinics than for schools and libraries. The Commission is not authorized to apply the discount mechanism for schools and libraries to rural health care clinics.

Nor does the Commission have the authority to base the rural subsidy on services that are not available to rural areas. Section 254(h)(1)(A) requires telecommunications carriers, upon receiving a *bona fide request*, to make the services available in rural areas available to rural health clinics at rates comparable to similar services available in urban areas. Clearly, a rural health care provider cannot make a bona fide request of services that are unavailable in a rural area.

Finally, the Commission should simplify administrative procedures and provide better outreach and education in order to increase program participation. Currently 9 percent of rural health care clinics participate in the rural health care program. By increasing participation to 50% would channel $60 million to rural health clinics. The Rural Health Care Division (RHCD) should also work closely with the Office of Rural Health Policy (ORHP) in the Federal

Department of Health and Human Services Agency of the Federal government. ORHP has a number of outreach programs to rural health care clinics. RHCD should work with ORHP to build upon them in order to make current and future grant recipients aware of the Rural Health Care Program. RHCD should also contact health and human services' departments in each state to undertake similar outreach campaigns.

The Commission would improve administrative efficiency by allowing rural health care clinics who have multi-year contracts, that were entered into as part of a competitive bid, to be able to receive benefits for the life of the contract under the urban and rural rates that existed during the year the benefit was approved by RHCD. Doing so would save each participant many hours of application time, and since rural rates have been marginally increasing on an annual basis, over-funding of rural health care clinics would be avoided.

II. Expand Eligible Health Care Providers To Include Entities Partially Engaged In Non-Eligible Activities

The Commission's rules currently disqualify a rural entity from receiving a rural health care discount if any part of the entity falls outside the statutory definitions of a health care provider.[3] The Commission asks whether it should adopt a less stringent interpretation of the 1996 Act to allow enteritis that are affiliated with eligible providers to be partly eligible for rural health care discounts, and if so, how to determine the discount, and guard against abuses.[4]

WorldCom supports a prorated discount for rural health entities that would be eligible for rural health care support were it not for their affiliation with non-eligible entities. WorldCom's experience as a provider of telecommunications services to many Native American health facilities leads it to agree with the Commission's observation that care is often provided in multi-

[3] 47 C.F.R. э54.601(A)(2)(ii).

[4] NPRM, &16, 17.

purpose facilities to multi-purpose entities, making the entire entity ineligible for benefits under the rural health care support program.

There is no statutory requirement for the Commission to exclude entities that would be eligible were it not for their affiliation with non-eligible entities, or their involvement in activities that are non-eligible for reimbursement under the rural health care program. The Commission has already used its discretion to allow partial funding for schools and libraries that are members of a consortium that share telecommunications facilities, where some of the consortium members are not eligible for reimbursement under the Schools and Libraries Program.[5]

The only question therefore, is how to choose a funding method which limits the benefit to the eligible entity, or the eligible portion of the entity. The most accurate method would be to pro-rate the benefit by the eligible entity's share of usage. Unfortunately, the services most utilized by rural health clinics, asynchronous transfer mode (ATM) service, and frame relay service, do not permit segregation of the circuits between eligible and non-eligible uses that would permit one to measure the eligible entity's share of usage. A reasonable alternative would involve estimating the share of staff hours devoted to patients being cared for by the eligible portion of the entity. Applicants could provide this estimate from records from a period of time prior to their application for benefits. A year average would control for seasonal variations. The Commission should allow an official representative to certify the accuracy of its estimate, and require the official to retain documents and workpapers used to make the estimate, which would be made available for review in the event the entity was audited.

[5] Cite 96-45 Order.

III. Internet Access Benefits Are Limited By Section 254(h)(1)(A)

In its Universal Service Order, the Commission provided discounts to eligible entities who incurred toll charges to access the Internet. Now that toll free access is universally available, the Commission asks parties to comment on whether it has authority to provide discounts for Internet access in the manner in which the Schools and Libraries Program provides discounts, rather than according to the difference between an urban and a rural rate.[6] The Commission appears to favor this option and argues that Section 254(h)(2)(A) and 154(i) of the Act give it the authority to support access to Internet service provided by non-telecommunications carriers.[7]

WorldCom agrees that Section 254(h)(2)(A) gives the Commission authority to subsidize access to Internet service provided by non-telecommunications carriers, but only to the extent permitted by Section 254(h)(1)(A). The Commission may only subsidize the difference between rates for urban and rural Internet access. Congress explicitly provided different funding mechanisms for rural health care clinics than for schools and libraries. This is why there are both Sections 254(h)(1)(A) and 254(h)(1)(B). Congress intended rural health care clinics to be able to utilize telecommunications and advanced services at rates on a par with urban health care clinics, and chose to accomplish this goal by means of an urban-rural rate equalization.[8] Congress' goal with schools and libraries was to promote telecommunications and advanced services to *all* schools, by providing a discount designed to promote affordable access, and so

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[6] NPRM, &23.

[7] Id., &22.

[8] Section 254(h)(1)(A)

Congress chose a subsidy mechanism based on affordability.[9] Now that Congress has spoken on the discount method to use for rural health care, the Commission no longer has discretion to use a different methodology.

Nor does the Commission have the authority to subsidize non-rural health clinics. Had Congress intended to promote telecommunications by all health clinics it would have done so. For this reason, the Commission must refrain from entertaining suggestions how to enhance access to non-rural health care providers so they might be better able to make their networks available to rural health care clinics in the event of a national security emergency.[10] This is a worthy goal, albeit one that is not currently authorized by Congress. The Commission must wait for a Congressional grant of additional authority before pursuing this goal.

IV. Proposed Changes To Discount Calculations Are Unsupported Or Are Outside The Commission's Authority

A. The Commission Does Not Have Authority To Base The Rural Subsidy On Services That Are Not Available To Rural Areas

The Commission observes that it may happen that some less expensive urban services are unavailable in rural areas, and health care providers are thus required to seek out actually available services, which may be more expensive than the least expensive urban services. Therefore, the Commission seeks ways to calculate discounts by comparing high speed services based on the functionality of the service from the perspective of the end user.[11]

WorldCom finds the Commission's identification of the problem vague and speculative. The Commission fails to identify which services are unavailable to rural areas, and the extent to

[9] Section 254(h)(1)(B).

[10] Id., &26.

[11] Id., &34-36

which this is a general problem. To WorldCom's knowledge all telecommunications services are generally available. There may be specific locations where some higher bandwidth services are not available, but these may be better dealt with on a case-by-case basis.

Moreover, the Commission's proposal would appear to fundamentally alter the manner in which discounts are calculated in a manner that subverts Congressional intent. Section 254(h)(1)(A) requires telecommunications carriers, upon receiving a *bona fide request*, to make the services available in rural areas available to rural health clinics at rates comparable to similar services available in urban areas. Clearly, a rural health care provider cannot make a bona fide request of services that are unavailable in a rural area.

B. Failing To Base The Rural Subsidy On The Most Comparable Urban Service Is Arbitrary, Capricious, And Could Inflate The Fund Without Limit

The Commission also seeks comments on how to address the "problem" that rural subscribers to satellite service do not receive any benefit because there is no difference between the rates for satellite services in urban and rural areas.[12] In adopting Section 254(b)(5), Congress directed the Commission to establish specific and predictable universal service programs. Section 254(h)(1)(A) requires the Commission to base the subsidy for services provided to rural health clinics on the rates for similar services found in urban areas. The most predictable and specific similar service to satellite service is satellite service. The Commission is therefore only authorized to search for similar services if a service found in a rural area is not available in an urban area. For this reason, the Commission must reject MSV's proposal to compare the rates for rural satellite service to urban terrestrial mobile services.

[12] Id., &38.

C. The Commission's Failure To Document The City Size Which Achieves Scale Economies Makes It Impossible To Reasonably Comment On Proposals To Redefine The Comparable Urban Area And Maximum Allowable Distance

The Commission states that a number of applicants have suggested that rates and services available in small cities with populations of 50,000 do not yet fully reflect the economies of scale and scope that are found in the most densely populated areas of the state, and that economies of scale are only achieved in larger cities.[13] The Commission fails to identify the parties providing this evidence, and also fails to directly supply the evidence itself. The Commission also fails to identify the city size that it believes does achieve economies of scale. Thus, it is impossible to identify the scope of the problem, impossible to determine the impact on the fund, and therefore impossible to provide a reasoned comment on the Commission's proposals to define urban area as any city in the state and the corollary proposal to eliminate the maximum allowable distance.

V. Simplifying Administrative Procedures And Providing Better Outreach And Education Are The Most Promising Methods To Benefits To Rural Health Clinics

As discussed above, only 9 percent of rural health care clinics participate in the rural health care program, and by increasing participation to 50% would channel $60 million to rural health clinics. The Commission should devote additional resources educating rural health clinics on the availability of the rural health care program and assisting them in the application process, as well as simplifying application procedures.

[13] Id., &41.

A. The Rural Health Care Division Should Work With Federal And State Health Agencies To Identify Rural Health Clinics And Educate Them About The Rural Health Care Program

The Schools and Libraries Division undertook a major campaign to educate schools and libraries of the availability of the schools and libraries program, held many seminars going through the application process, explaining forms, offering tips, and providing advice. Efforts of similar scale and scope have not occurred with the rural health care program. The Rural Health Care Division (RHCD) should also work closely with the Office of Rural Health Policy (ORHP) in the Federal Department of Health and Human Services. RHCD should work with ORHP to build upon the various outreach programs of ORHP in order to make current and future grant recipients aware of the Rural Health Care Program. Finally, RHCD should contact health and human services' departments in each state to undertake similar outreach campaigns.

B. The Commission Should Make It Easier To Apply To The Rural Health Care Program

Making it easier to apply to the Rural Health Care Program would also increase participation rates. Rural health care clinics are often under-funded and suffer from high rates of staff turnover. One common consequence of this is the failure of many health clinics to reapply, even if they had been funded. New staff members at these clinics often perceive carrier information about the Rural Health Care Program as a marketing effort. One remedy for this problem might be for the RCHD to send reminders to funded rural health care clinics who fail to renew their applications to reapply to the program.

Reducing the time it takes clinics and carriers to fill out their respective forms would also improve participation rates. The reason for the lengthy application delay, which results in a lengthy benefit delay, is due to the lengthy time of carriers must spend researching the applicable urban rate for each applicant in order to calculate the urban-rural rate differential. WorldCom

understands that the RDHD will soon publish the urban rate for each urban area. This will greatly increase the speed with which applications can be completed and then processed.

Finally, WorldCom has many multi-year contracts with rural health care clinics. It is time consuming to calculate urban and rural rates, and to fill out and submit new forms every year. WorldCom recommends the Commission allow rural health care clinics who have multi-year contracts, that were entered into as part of a competitive bid, to be able to receive benefits for the life of the contract under the urban and rural rates that existed during the year the benefit was approved by RHCD. Since rural rates have been marginally increasing on an annual basis, this proposal would not result in over-funding of rural health care clinics. Clinics might prefer to reapply every year in order to obtain higher benefits, but giving them the option to avoid reapplying every year would improve administrative efficiency and increase participation.

VI. Conclusion

For the reasons stated herein, WorldCom urges the Commission to adopt the positions advocated in these Comments.

Sincerely,

Larry Fenster

Larry Fenster

Statement of Verification

I have read the foregoing and, to the best of my knowledge, information and belief, there is good ground to support it, and it is not interposed for delay. I verify under penalty of perjury that the foregoing is true and correct.

Executed on July 1, 2002

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